**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

PROVIDENCE MEMEORIAL HOSPITAL
2001 N OREGON
EL PASO TX 79902

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

**Respondent Name**
INSURANCE CO OF THE STATE OF PA

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-07-4166-01

**MFDR Date Received**
MARCH 5, 2007

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "According to Workers Compensation statues the stop-loss threshold is reached once charges exceed $40,000.00 and reimbursement admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%."

**Amount in Dispute:** $20,540.20

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Attached is the incomplete DWC-60. Carrier cannot complete the DWC-60, Part V, Table of Disputed Services. The Table submitted by the Requestor references DOS 5/13/06 to 5/27/06 for a total of $43,626.93. Carrier has no record of receipt of any such bill. These DOS and amount match do not match the Request for Reconsideration, the UB-92 submitted or the MR-100. The February 21, 2007 Request for Reconsideration from Requestor references DOS 12/29/06 and an amount of $119,898.42. This Request for Reconsideration does not match the DWC-60, Table of Disputed Services, the UB-92, or the MR-100. The Carrier has not record of receipt of any such bill. The UB-92 attached to this Request references DOS 11/29/06 and an amount of 116,898.42. This does not match the Table of Disputed Services, MR-100 or the Request for Reconsideration. The MR-100 references DOS 05/13/06 to 05/27/06. This does not match the DWC-60, Table of Disputed Services, the Request for Reconsideration, the UB-92 or any records of the Carrier. This Request must be dismissed. The Request is incomplete, undocumented and internally irreconcilable. There is no documentation of a Request for Reconsideration for the DOS listed on the DWC-60, Table of Disputed Services. Carrier cannot otherwise reasonable respond to this Request in its present form."

**Response Submitted by:** Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 13, 2006 – May 27, 2006 | Outpatient Hospital Services | $20,540.20 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - EOBs submitted document date of service November 29, 2006; therefore, they are invalid for the dates of service in dispute.

**Findings**

1. In accordance with 28 Texas Administrative Code §133.307(e)(2) Each copy of the request shall be legible, include only a single copy of each document, and shall include: (A) a copy of all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.304; (B) a copy of each explanation of benefits (EOB) or response to the refund request relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB; (C) a table listing the specific disputed health care and charges in the form, format, and manner prescribed by the commission. In reviewing the documentation submitted by the requestor, the dates of service (May 13, 2006 through May 27. 2006) listed on the Table of Dispute Services do not correspond with the documentation submitted. The Requestor has not met the requirements of the rule; therefore, Medical Fee Dispute Resolution cannot review the merits of the dispute.

**Conclusion**

The Division concludes that the requestor failed to submit their request for medical fee dispute resolution in accordance with Division rules. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | October 31, 2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.